Goals and Benchmarks Workgroup Meeting Minutes

12/19/2007
1 pm to 4 pm
AARP Office
Bismarck, ND 58501

Attendees: Doug Wegh, Hettinger County Social Services; Linda Wurtz, AARP ;Bruce Murry, ND Protection and Advocacy; Bob Puyear-Bismarck; Shelly Peterson, ND Long Term Care Association; Linda Wright, ND Dept of Human Services, Aging Services Division ; Royce Schultze, Dakota Center for Independent Living ; Jake Reuter, DHS, Money Follows the Person Grant Program Manager; Gloria Glasgow Ward County Social Services

Documents Provided: MDS Assessment-Sections A-J and O-Q; AARP Public Policy Institute-Talking Points "Presumptive Eligibility"

1. The Minimum Data Set (MDS) document sections B, G, and Q were reviewed with the committee as they pertained to the MDS Data Probe on potential MFP participants.

2. The MDS data probe that was requested was discussed. The probe found 322 individuals that had expressed the preference to return to the community. About 25 of those had a diagnosis of Alzheimer's disease. It was found that when applying the eligibility criteria established in the grant application almost all potential referrals were eliminated from the pool.

- The need for assistance with toileting was noted to be the care need that most often results in someone either entering or returning to the nursing facility. Assistance with toileting is generally a priority. Alternatives such as catheters were reviewed as a means of addressing this. Concerns related to infection were raised as a limiting factor to catheterization.
- The issue that the committee noted to be of most importance was the support system in the community and not the various needs identified in the MDS.
- It was noted that if the right support system could be developed that persons with significant needs could transition successfully. The right supportive environment will be the critical factor when transitioning.
- Family support or family homes, Adult Family Foster Care could serve persons that could not be served in an alternative environment
- The need for more Adult Family Foster Homes were identified by the group -Grand Forks is an area that is need of more Homes

- Instead of identifying an arbitrary cut off based on current ADLs it would be better to assess needs and determine if the needed support services could be identified to meet the person's needs.
- The MFP requirements that would need to be applied included: 6 months in the Nursing Home, MA eligible, and continuing to meet level of care. **Level of dementia?**
- It was suggested that anyone that indicates the preference to return to the community could be referred for an assessment. The idea of the Transitional Coordinator meeting with the NF social worker to discuss support needs was discussed at length. Review of available services in the area with the HCBS Case Manager was also thought to be important at this step in the process as well as to discuss possible past services in the community.
- It was noted that in more rural areas of the state it will be even more important to involve the HCBS Case Manager early in the process due to the limited service providers. The individual moving would be involved with QSP identification as part of the self-directed process. QSP development is a process that usually takes some time.
- A concern about the HCBS Case Manager not being reimbursed for services was discussed by the group. Sometimes the needs of the Transitional Coordinator and the NF Social Worker could be address by a phone call once a release of information is in place.
- Family members are used to being very involved with NF residents at this time. It was noted that it would be very important to involve them as soon as possible in this process. It was noted that the process will most times not work well if they are not involved. It was also noted that there will be situations where the family involvement could be problematic due to past exploitation or other similar concerns. The NF social worker will be able to communicate this concern from the start if they are involved.
- It was thought that face to face communication of MFP eligibility to NF would be the most effective method.
- The release of information allowing communication between the Transitional Coordinator, the Nursing Facility, and the HCBS Case manager will be very important. It was noted that the TC will have access to the SAMS information system so they may be able to determine if a referred individual has received HCBS in the past.
- An option for Web based information was reviewed and it was noted the NDSU Data center is very good.

- It was noted that once someone with a diagnosis of Alzheimer's is place into a nursing facility it is very hard to have them return home. Family members usually have taken

care of their loved one to the extent possible and are exhausted. **Also, it is unlikely that the individual will see improvement.**

- Nursing facilities are currently assisting between one third and one fourth of their residents with a discharge either back home or to a lower level of care. The question of when to involve the Centers for Independent Living was raised in relationship to this current process. It was noted that the CILs would likely be called for the more challenging situations. If the NF social work staff sees the CILs as a positive and useful resource they will utilize their services more often or when they have a more difficult discharge situation. This is a system process that will need to be clarified and communicated.
- NF discharge planning has always been done and is mandated by federal regulation. Concern is noted that the history shows that programming/finances to provide support services in the community decrease when the available money from the legislature to providers decreases.

3. Review/Revise Goals
   - The question of what type of system do we wish to design was raised. Do we want a system that meets the needs of all people in need of assistance? It was agreed that the goal would be to serve all folks needing community services.
   - It was noted again that 1 in 4 NF residents are discharged from the NF and 1 in 3 return to some type of lower level of care such as Basic Care
   - Development of a system that could serve all individuals in need of support services in the community would make the MFP grant process a success.

   Goals:

   - Develop a process to assist individuals with moving out of institutions and to assure that they get the care that they need
   - Document unmet needs, identify needed services and seek the funding **(and/or process)** to "fill the gaps" in the service delivery system
   - Provide services to those persons that would not have naturally moved out of the nursing home-
   - -NF will Continue to discharge those individuals that wish discharge to their home/community in a timely manner
   - Will establish a state wide education process to educate the public about LTC Services

   Education is needed about the need for more services, what services are currently available and how to get those services. The ADRC could play the key role in this

communication process. The LTC partnership program could play a role in this education as well. Curt Volesky is in charge of this program and would be helpful to have him discuss this program at the next Stakeholder meeting.

- (ADRC Mission) to do the education
- (Partnership Program)-Medicaid/Private Nursing Home Insurance

4. Review/Revise Barriers/Gaps
    - We need to address the medically needy level again. It was raised in the last session but was not passed. Sustaining the change if the economy takes a downturn was noted to be one reason the legislature may have had for not passing the change. It was also felt that, with the amount of money available to the appropriations committee, there was a tradeoff in order to give providers 4% and 5% increases for the biennium.

    - SSI recipients currently are allowed to keep all of their SSI checks and it was hoped that the medical needy spending level could be brought up to that level if not higher to allow people to live in the community.
    - QSP travel time especially in rural areas of the state was noted to be of concern. Sometimes a QSP has to drive 30 minutes to provide an hour of care. Can we track drive time as it is not being tracked at this time? County and agency QSP staffs do get mileage at this time.
    - The Department of Transportation will be provide a website with all providers listed and in Jan/Feb of 2008 will also include their routes
    - It would be very important to track the travel issue so that it can be communicated to the legislature. Without data it is very hard to convince the legislature of the need.
    - Support services when someone is ill, back from surgery, dressing change etc (increase in care need)
    - Short term stay in Nursing home (2-3 days)

5. Four Primary Objectives:

    a) Rebalancing: Increase use of HCBS
    b) Eliminate barriers that prevent/restrict flexible use of Medicaid funds for Long Term Care in Home and Community Based Services
    c) Assure continued provision of HCBS after 1-year transition period

d) Assure at least the same level of QA for MFP participants as available to other HCBS beneficiaries

- The Quality Workgroup will be addressing the Quality Management System for the MFP grant. The Goals and Benchmarks workgroup will be able to review and offer additional suggestions for the process.

6. How will MFP further and/or complement ND's rebalancing efforts? How will MFP strengthen previous or existing rebalancing and institutional transitioning program initiatives?
    - It was agreed that a significant efforts by the state related to the development of community DD services will need to be reflected in this section of the protocol. The improvement in services to persons that are aging or with a physical disability will be outlined but are not as dramatic as those of the DD service system.
7. Discussion about how the enhanced Federal Medical Assistance Participation will be used to permanently rebalance the LTC system towards HCBS was briefly discussed with the following ideas suggested:
   Medically needy spending
   Increase ISLA funds for the regions
   Affordable Housing/Assisted Living Placement supplement
   Members will continue to offer other Ideas for this funding
   Home Modification

8. Benchmarks:

- Establish an Aging and Disabilities Resource Center (ADRC)
  It was agreed that this benchmark addresses the significant need for public education and needs to be continued as it is in place at this time.

- **To assist in rebalancing the state's long term care system, we will create a stakeholder committee led by the project manager for MFP in 2008**

  This benchmark was found to be redundant as the MFP grant requires the development of a stakeholder committee. An alternative benchmark may be more beneficial will be considered.

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- The benchmark set to develop a crisis intervention response team was reviewed. The workgroup recommended that this be changed to read as follows:
  ND will create a crisis intervention/response system/process by 6/30/2008 to support:

1. Individuals who have transitioned from an institution to the community

2. Individuals currently in the community who might otherwise require institutional services but for the availability of this service. (2010) Target date

Discussion related to back-up services and crisis response

- Will need a 24-hour on call system as part of the grant QA process
- What are we going to do for more rural area as there are few services available
- Large cities may have an agency to provide this service
- The Florida 24-hour back-up plan was reviewed
- It was agreed that a multi-tiered approach would be an reasonable response to address this need
- Would HCBS case manager have to be on call?
- Could we pilot a 24-hour back-up system to be provided by a nursing home?
- Staffing will be an issue in the nursing home
- What about offering "short term admissions" for illness, injury, loss of provider
- Usually the local emergency room or ambulance service is called now
- Police are the contact for some rural HCBS recipients
- What about the need for 24-care when someone is ill as little or no funding or staffing is available to go into assist
- Need to have someone to check in on folks
- Family supports will be critical for moves into the community at time when someone is ill
- Informal networks will need to be developed-part of the transitional coordinators role
- Health Department is developing a disaster plan with Nancy N. of Medical services address the vulnerable population
- The 211 system could be used
- Will need to build in law enforcement and other EMS systems
- Gatekeeper program in past helped support the informal or natural support networks for individuals in the community-Only going in one part of the state
- Lifeline services will be needed.

9. Other Items

- It was noted that we need to monitor and document what services are working, where they are working. We need to know why someone is readmitted to the NF after they transition. We will be able to get 5 years of data with the SAMS documentation system playing a key role in data collection.
- PACE program training for the MFP Stakeholder Committee will be scheduled
- The presumptive MA eligibility was not discussed

- Jake Reuter will offer the goals and barriers/gaps in a format that can be reviewed and finalized at the next meeting

Next Meeting 1-17-08; 1pm to 4pm; AARP Office, Bismarck, ND